HEALTH AND SPORT COMMITTEE

SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

SUBMISSION FROM [Dr Andy Kirkland]

I am a lecturer in sports coaching, a British Association of Sport & Exercise Scientist, a Chartered Scientist and an applied practitioner.

1. To what extent does social prescribing for physical activity and sport increase sustained participation in physical activity and sport for health and wellbeing?

Firstly, the question and title of the consultation is a problematic one. Sport & physical activity (PA) are not the same thing. This common mistake has been made by the Scottish Government and Westminster and conflicts with the World Health Organisation’s definition of PA. Conflating sport & PA both in terms of policy and funding, especially when tasking traditional sporting organisations (such as sportscotland & NGB’s), dilutes focus and less may be achieved as a result.

To what extent social prescription is effective depends on what is prescribed, who prescribes it and the motivations/perceived barriers the participant faces in adhering to interventions. ‘Interventions’ such as ParkRun are effective because they are built on strong foundations of community and inclusiveness i.e. they build social capital. Participants who see others like themselves are more likely to believe they can succeed and will invest the effort to do so.

Interventions that fail to develop social capital, that are delivered by professionals who ‘look like’ sports people, are overly structured within short-medium timeframes, with finite funding cycles are far less likely to work in the long-term.

2. Who should decide whether a social prescription for physical activity is the most appropriate intervention, based on what criteria? (e.g. GP, other health professional, direct referral from Community Link Worker or self-referral)

I have conducted research with colleagues in this area, using models to explore barriers to successful PA interventions. There are several important factors to consider:

- Healthcare providers are not sufficiently trained, tend not have the knowledge or confidence to recommend PA prescription. For example, medical students and nurses typically receive a few hours of lecture-based training over their entire study. Rather, focus is on treating pathologies and dealing with illness than preventing them.
• Healthcare providers tend to believe that, whilst they see the benefits of social prescription, that it is someone else’s responsibility to deal with it. That is a) because they don’t feel sufficiently trained to do so, b) that they lack agency to deliver interventions such as social prescription when they believe patients want a ‘quick fix’ i.e. a prescription for the chemist.

• Community Link Workers may be helpful if there are enough of them within communities and community-based activities are available to do things people feel confident in doing.

• Self-referral, or referral from friends in the community is probably best. As with my previous comment, developing social-capital to enable a snowball effect to occur is probably best.

3. What are the barriers to effective social prescribing to sport and physical activity and how are they being overcome?

Again, sport and PA must not be conflated, as the barriers are very different. Therefore, the first barrier that needs removing is to separate sport from physical activity in terms of policy making. Further, recognition of the complex, multifaceted nature of society needs to be accounted for. The link between health, PA, active transport, diet, education and local government must be considered together, driven by a good evidence-based joined-up policy rather than rhetoric.

**Sport:** Sport typically requires facilities that need to be paid for. Government focus of using sport to encourage PA has tended to result in funds being diverted towards PA initiatives, the (very basic) training of PA activators and away from traditional core activities of NGB’s. It is my belief that this is alienating NGB members who’s needs aren’t being served. This affects their ability to grow membership and develop sport. As a coach developer at UK level, I have seen resources to support the professional development of coaches drop i.e. a deskilling of the industry. I suggest, therefore, greater separation between Sport & PA at government and sportscotland level in which sports can focus on their core activities.

**Physical Activity:** As everyone recognises, inequality in society is probably the biggest barrier. There are no ‘quick-fixes’. Rather, continued investment in education, in which PA is as important as academic attainment is required. This involves re-investing in expert physical education teachers and primary school teachers. It also involves ensuring curriculums have sufficient scope to allow pupils to exceed WHO recommendations on PA. Long-term strategies and political consensus within the Scottish Government is required, to overcome short-term political thinking within compartmentalised portfolios.

Active transport is also key, in which the political will to tackle the ‘car culture’ is required. Cities do not feel safe in terms of cycling and pollution makes walking less pleasant. Again, there are no short-term solutions but planning requirements must prioritise active transport and restrict car use i.e. congestion charges, re-nationalisation of the transport network to remove the barriers to active transport are required.
4. How should social prescribing for physical activity and sport initiatives be monitored and evaluated?

Mixed-methods are required, in which qualitative data is prioritised over quantitative data. Whilst it is easy to focus on growth figures, case-studies exploring what works and what does not work and why is probably more valuable. Metrics relating to social value & social return on investment tell us more about the effectiveness of interventions that ‘the number of bums on seats’.

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